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ABSTRACT

Alcoholism, a major health problem currently being addressed by other professions, has unique features, manifestations, and ramifications for psychologists. Salient aspects of alcoholism in psychology include etiological and motivational factors, characteristic behaviors, and specific risk factors in the work environment of psychologists. Alcoholism, conceptualized as a deeply embedded permanent addiction not resolvable by conscious, planned effort, constitutes a special dilemma for psychologists in that many psychologists strongly believe in the powers of the mind and in the capacity to comprehend and alter behavior. This paper reviews current efforts to deal with alcoholism in an effective and humane manner within the professions; these efforts are usually modeled after the self-help principles of Alcoholics Anonymous in combination with professional treatment. Included are present efforts in psychology to deal with alcoholism among psychologists. Although interest in alcoholism within the professions runs high, specific programs and data regarding alcohol problems among psychologists remain limited. The literature reviewed focuses on five areas: (1) Defining, diagnosing, and identifying alcoholism; (2) Alcoholism among professionals: nature and scope of the problem; (3) Prevalence of alcoholism among professionals; (4) Treatment of alcoholism for professionals; and (5) Alcoholism among psychologists. "Citations of particular relevance to educators cover: (1) alcohol impaired university professors; (2) problem drinking among first-year medical students; (3) alcohol use among nurse educators; (4) substance abuse among medical trainees. (RJM)

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ALCOHOLISM AMONG PSYCHOLOGISTS: A REVIEW OF THE LITERATURE

A Doctoral Research Paper

Presented to

the Faculty of Rosemead School of Psychology

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In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Rebecca J. French

April 1994

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ABSTRACT

ALCOHOLISM AMONG PSYCHOLOGISTS: A REVIEW OF THE LITERATURE

by

Rebecca J. French

Alcoholism, a major health problem currently being addressed by other professions, has unique features, manifestations, and ramifications for psychologists. Salient aspects of alcoholism in psychology include etiological and motivational factors, characteristic behaviors, and specific risk factors in the work environment of psychologists. Alcoholism, conceptualized as a deeply embedded permanent addiction not resolvable by conscious, planned effort, constitutes a special dilemma for psychologists who hold a strong belief in the powers of the mind and in the capacity to comprehend and alter behavior. Current efforts to effectively and humanely deal with alcoholism within the professions, usually modeled after the self-help principles of Alcoholics Anonymous in combination with professional treatment, will be reviewed, including the present efforts in psychology to deal with alcoholism among psychologists. Although interest in alcoholism within the professions runs high, specific programs and data regarding alcohol problems among psychologists remain limited. The literature reviewed will focus on five areas: (a) defining, diagnosing, and identifying alcoholism, (b) alcoholism among professionals: nature and scope of the problem, (c) the prevalence of alcoholism among professionals, (d) treatment of alcoholism for professionals, and (e) alcoholism among psychologists. A brief discourse regarding methodological considerations prefaces the review.

TABLE OF CONTENTS

DOCTORAL RESEARCH PAPER PAGE

Introduction....1

Methodological Considerations....3

Review of Empirical Research....6

Defining, Diagnosing, and Identifying Alcoholism....6

Alcoholism Among Professionals: Nature and Scope of the Problem....17

The Prevalence of Alcoholism Among Professionals....29

Treatment of Alcoholism for Professionals....34

Alcoholism Among Psychologists....47

Implications for Further Research....62

Summary and Conclusions....65

REFERENCES....67

ALCOHOLISM AMONG PSYCHOLOGISTS: A REVIEW OF THE LITERATURE

Introduction

The problem of chemical dependency, particularly alcohol abuse and alcoholism among professionals has received major attention over the last twenty years, publicly and professionally (e.g., Bissell & Haberman, 1984; Bissell & Jones, 1976; Thoreson et al., 1983). Psychologists are showing considerable interest in the field of alcoholism, both in the conduct of research and in clinical practice. Federal support of alcoholism treatment and research within the past two decades has led to advances in alcoholism treatment evaluation and new perspectives on alcoholism (Emrick & Hansen, 1983; Moos & Finney, 1983; Moos, Finney, & Cronkite, 1990; Thoreson et al., 1986a, 1986b; Thoreson & Skorina, 1989).

Although there has been increased interest in research and consequent new knowledge, most research on job performance and alcoholism has focused on the blue-collar worker rather than on the professional, and there still remains an astonishing lack of understanding about alcoholism (Vaillant, 1983). Specific information about alcoholism among professionals is relatively scarce and empirical data on the alcohol-related job experiences of these groups is limited (Thoreson, Nathan, Skorina, & Kilburg, 1983). This is true despite the upsurge of alcoholism treatment programs and employee assistance programs (EAPs) in industry and higher

education directed toward professional-executive employees (McCrady, 1989; Van Den Bergh, 1991).

The actual prevalence of alcoholism among professionals, including psychologists, is difficult to estimate. Prevalence of alcohol problems and incidence of alcoholism among professionals is based primarily on clinical reports from treatment groups or on conjecture (Thoreson, Budd, & Krauskopf, 1986a). General population surveys estimate that 6 to 10 percent of those who drink develop alcoholism. Estimates of alcoholism among various mental health professions lean toward the upper end of this range despite low anticipated rates for the professional, considering cultural and demographic characteristics. The estimated prevalence rate of alcoholism among psychologists ranges from 6 to 9 percent (Thoreson et al., 1983; Thoreson, Miller, & Krauskopf, 1989). Determination of exact prevalence rates appears to be infeasible because estimates are a function of both particular methods and the definition of alcoholism. The critical factor is not to estimate the exact number but to realize that a substantial number of psychologists suffer adverse consequences due to alcohol abuse, including work-related impairment (Thoreson et al., 1986a; Thoreson & Skorina, 1989).

Issues concerning the provision of alcoholism treatment to professionals are receiving increased attention in the literature. It is important to identify and intervene in the early stages of alcoholism, if possible. Failure to recognize and diagnose alcoholism in professionals means that their recovery is delayed, and they may not recover at all (Skorina, Bissell, & DeSoto, 1990). Researchers have found that professionals, including psychologists, rarely receive formal intervention from or attain

recovery through the actions of colleagues (Bissell & Haberman, 1984; Thoreson et al., 1983; Thoreson, Budd, & Krauskopf, 1986a, 1986b).

Alcoholism is one of the major health problems of our society (Efron, Keller, & Gurioli, 1974), and chemical dependency has been noted as the major cause of decline in performance among professionals (Thoreson & Skorina, 1989). Alcoholism can be a life-threatening and career-threatening disease. This paper focuses on the major problem of alcoholism as it pertains to professionals, and in particular, to psychologists. A review of possible risk factors for those in the profession of psychology is included. The purpose of this paper is to examine the nature and scope of alcoholism among psychologists, and to explore current efforts in treatment and intervention strategies. Research is reviewed evaluating the effectiveness of treatment strategies and future recommendations are noted.

Methodological Considerations

The studies discussed in this paper are empirical in nature and examine a variety of issues regarding the nature and effects of alcoholism among professionals and the effectiveness of treatment strategies. Alcoholism is difficult to define. There are many diverse definitions of alcoholism; however, the definition used by the investigator influences prevalence rates, the resulting magnitude of the problem, and subsequent treatment strategies. Inadequate definitions of alcoholism have often been cited as the primary reason for lack of success in developing adequate epidemiological, diagnostic, prognostic and prevention endeavors (Mendelson & Mello, 1985; Thoreson & Skorina, 1989). The definition of "success" is also critical to studies in the area of alcoholism. Success may be defined as

returning to practice, as complete abstinence from alcohol and other drugs, as ability to practice without impairment, or as moderate, nonproblem use of alcohol and drugs. Each of these definitions yields a different success rate for treatment (McCrady, 1989). Due to the nature of this area of research, there are inherent difficulties in the methodology which unfortunately jeopardize the internal and external validity of these studies. The high incidence of denial among alcoholics and those around them, stigma and the nature of professional work, make hard data difficult to obtain.

Although some of the studies employed more than one method of inquiry (survey data, observation, interviews), most relied more heavily on survey data (questionnaires and inventories). Findings from survey data, or self-report data, often are superficial and limited, and there is extremely limited experimental control. Underreporting of alcohol use may occur in 25 percent of individuals who drink (Gerace, 1988); however, Mayer (1983) concluded that questionnaires and inventories of psychological and behavioral variables used for identifying alcoholics and problem drinkers are the most sensitive instruments for identifying alcoholism. Moos, Finney, and Cronkite (1990) report that although many clinicians and some researchers have expressed reservations about the accuracy of self-report data from alcoholic patients, reviews of the research literature on this topic suggest that, given certain conditions, self-report data are both reliable and valid. Validity and reliability of self reports for alcoholics have been reported by other researchers as well (e.g., Armor, Polich, & Stambul, 1978; Sobell & Sobell, 1978; Williams, Aitken, & Malin, 1985).

Most estimates of prevalence of alcohol among professionals were based either on data from treatment groups or on hunches from clinical

experience. Due to the high denial rate it is difficult to estimate accurate prevalence rates. As a result of the arbitrary lumping of respondents into various levels of consumption that may or may not constitute alcohol misuse for a given person, survey research methods may tend to overreport incidence rate. Conversely, given the strong probability that much alcohol abuse and alcoholism remains untreated, clinical studies from hospitalized patients probably underreport the true incidence of alcohol abuse and alcoholism. Given the present state of knowledge, there is no way of determining the exact prevalence rates for alcohol abuse and alcoholism among psychologists (Thoreson & Skorina, 1989).

It is argued that the high level of abstinence reported in the literature for posttreatment alcoholics is likely to be based on biased subgroups (Emrick & Hansen, 1983). Considering the likelihood that alcoholism is a chronic, long-term medical condition and that continuous sobriety is more often the exception than the rule, it is important to develop posthospital support systems and to establish methods to reduce relapse in working with alcoholic psychologists.

Most of the studies that have focused on psychologists with alcoholism have been latitudinal, that is, completed at one point in time. Non-longitudinal studies fail to adequately account for certain changes which have occurred over time, and a measure taken at only one point may seem to imply a relationship between two variables. A second or third survey given at a later date may reveal that certain changes or effects which were observed and attributed to a particular variable are actually better accounted for by another variable.

Control groups were not present in most studies, with the exception of

Moos, Finney, and Cronkite (1990) who studied a matched group of normal-drinking families who lived in the same census tracts as the alcoholic patients and their families. Almost all of the reviewed studies lacked objective or reliable baseline data concerning drinking patterns before entering the professional field or before becoming a psychologist. Although it is understandable that the nature of studying alcoholism among psychologists and other professionals lends difficulty to obtaining baseline data or using control groups, this lack of control lends to poorer internal validity of the study, making the results more tenuous.

Lastly, it is understood that the data presented here is correlational in nature. This means that the results of the studies can demonstrate that there are relationships between given variables, but they cannot conclusively determine that these correlational relationships are causal.

Review of Empirical Research

Defining, Diagnosing, and Identifying Alcoholism

The term alcoholism may be defined and interpreted in many ways, often meaning what the user chooses it to mean. There is much disagreement and controversy over what constitutes alcoholism. Rarely are alcohol abuse and/or dependence and problem drinking systematically defined (Bucholz, Homan, & Helzer, 1992; Mendelson & Mello, 1985; Thoreson & Skorina, 1989). Not many would argue with the fact that alcohol abuse, whether defined as a disease, a bad habit, or a culturally induced behavior pattern, brings with it a large number of medical, familial, social, and work problems that dwarf those of any other so-called disease in our

society (Thoreson & Skorina, 1989; Vaillant, 1983). However, because alcohol misuse comes in a variety of forms with many differing symptoms and appearances, fitting all of these manifestations into a well-defined disease model seems impossible (Armor, Polich, & Stambul, 1978; Mendelson & Mello, 1985; Peele, 1984; Thoreson & Skorina, 1989; Vaillant, 1983).

The classification of alcohol misuse as a moral failing, a bad habit, or a disease has been the subject of major attention over the past 25 years. The belief that alcoholism is a moral problem has, in part, been rejected; however, the stigma that is attached to self-inflicted diseases remains. Thoreson and Skorina (1989) report that the scientific/treatment community tend to take either of two main positions on this issue. Those on the social science side tend to prefer the term "alcohol misuse" to "alcoholism" and to view the syndrome as a deeply imbedded habit or behavioral excess that carries with it a variety of problems. The use and misuse of alcohol from this perspective is viewed primarily as being a behavior disorder. It is a learned habit. It has familial and cultural correlates and is considered amenable to change through the use of methods known to the social sciences for altering behavioral patterns. On the other hand, the medical/treatment community tend to prefer the term "alcoholism" and to place it within the framework of the disease model.

Psychologists tend to be concerned about the current trend in our society toward medicalization of self-induced problems. They may have difficulty accepting alcoholism as a disease, preferring an intrapsychic or learned model subject to control of the intellect. Conversely, many of the medically based alcohol treatment community point to the reluctance of the behavioral scientists to fully accept the reality that alcohol misuse, although

characterized by a highly variable symptom pattern, is an illness that, if left untreated, has severe and life-threatening consequences (Moos, Finney & Cronkite, 1990; Thoreson, Budd, & Krauskopf, 1986a; Thoreson & Skorina, 1989). Vaillant (1983) arguing for the disease model, reported results of an 8-year follow-up sample of 100 alcoholics posttreatment. Approximately one third of the sample maintained abstinence, one third continued to drink, and one third were deceased, primarily as a result of medical complications of sustained alcohol misuse. Vaillant offered this thought to the behavioral scientists: Although alcohol misuse is in part a behavioral disorder and is often better treated by psychologists skilled in behavior therapy than by physicians, giving up alcohol abuse often requires skilled medical attention during the period of acute withdrawal. Furthermore, alcoholics have a mortality rate two to four times higher than that of the average person.

The model one chooses has profound significance, with respect to both type and numbers of persons who are classified as having alcohol problems. It is noted that limiting alcoholism to mean only those who have developed physical tolerance, withdrawal states upon ceasing to drink alcohol, and the diseases associated with alcoholism excludes alcohol-dependent people who may have suffered few or none of these consequences. It seems clear that family, interpersonal, school, and work problems associated with alcohol misuse occur for many people who are not physiologically dependent on alcohol (Thoreson & Skorina, 1989; Vaillant, 1983; Mendelson & Mello, 1985).

Any conceptualization of alcoholism must include consideration of how much loss of control there is, how much physical dependence there is, and how problematic the drinking is and to whom. The complexity of the issue

has led some observers to suggest that there are as many alcoholisms as there are alcoholics (Thoreson & Skorina, 1989). Alcoholics Anonymous takes a phenomenological stance that alcoholism is defined by individual perceptions of powerlessness and unmanageability regarding alcohol use (Alcoholics Anonymous, 1975-1986). However, there are a variety of diagnostic schemes that have validity in delineating symptoms and problems related to alcohol abuse. They provide a means of classifying alcohol problems in ways that lead to some consistency in definitions and diagnosis.

Definitions of alcoholism are diverse. The definition used by the investigator influences prevalence rates, the resulting magnitude of the problem, and subsequent treatment strategies. Inadequate definitions of alcoholism have often been cited as the primary reason for lack of success in developing adequate epidemiological, diagnostic, prognostic, and prevention endeavors (Mendelson & Mello, 1985; Thoreson & Skorina, 1989).

Criteria for diagnosing alcoholism are generally divided into one of three categories as shown in the criteria set forth by the National Council on Alcoholism [NCA] as cited by Mendelson and Mello (1985) and Thoreson and Skorina (1989). These are (a) physical dependency, (b) clinical medical symptoms, and (c) behavioral, psychological, and social aspects. As reported by Thoreson and Skorina (1989) regarding the NCA Criteria:

> The criterion distinguishes among three kinds of data: behavioral (psychological and attitudinal), physiological, and clinical. Signs and symptoms designated under *diagnostic level 1* contain classic signs of alcoholism. Physiologically, there may be dependence, increased tolerance, and heavy daily consumption. Clinically, the illnesses of alcoholic hepatitis and alcoholic cerebellar degeneration are diagnostic

> criteria. Behavioral criteria includes drinking despite strong medical and social contraindications of known consequences. *Diagnostic level 2* represents probable alcoholism. The physiologic criterion is alcoholic blackouts. Clinically, there are a variety of illnesses such as Laennec's cirrhosis, Wernicke-Korsakoff syndrome, and alcohoic myopathy or cardiomyopathy that may be evident. The behavioral criterion is the subjective complaint of loss of control of alcohol consumption. *Diagnostic level 3* is characterized as potential or incidental for the diagnosis of alcoholism. No physiological or behavioral criteria are designated at this level. Clinical manifestations such as anemia, pellagra, and gastritis may be evident but are insufficient diagnostic criteria (p.81).

Particular definitions emphasize one or the other of these criteria and may, in turn, add a special emphasis on the interrelationship of alcohol abuse and alcoholism with work and socially related problems. In general, the more stringent the criteria, the more confident the diagnosis, and the more limited the number of alcohol abusers who fit these criteria. Conversely, the more liberal the criteria, the less confident the diagnosis, and the greater the number of alcohol abusers so classified (Magruder-Habib, Durand, & Frey, 1991; Thoreson & Skorina, 1989).

Mendelson and Mello (1985) noted that the diagnosis of alcoholism has always been complicated by the criterion problem. For example, the National Council on Alcoholism's previously mentioned criteria; serious problems associated with drinking, physiological dependency, and medical complications, are diagnostic indicators that are used in several definitions of alcoholism. Because of the stigma and the denial of alcoholism in our society, people with symptoms in any or all of these categories will be excluded from

diagnosis of alcoholism and included only if serious health or job-related problems evolve (Thoreson & Skorina, 1989).

The World Health Organization [WHO] offers more liberal definitions that include behavioral and cultural critieria of alcoholism and which recommends that the term "alcoholism" be abandoned and replaced by the phrase "alcohol-type drug dependence." The WHO definition of this disorder is as follows:

> Drug dependence of the alcohol type may be said to exist when the consumption of alcohol by an individual exceeds the limits that are accepted by his [or her] culture, if he [or she] consumes alcohol at times that are deemed inappropriate within that culture, or his [or her] intake of alcohol becomes so great as to injure his [or her] health or impair his [or her] social relationships (Mendelson & Mello, 1985, p. 3).

The WHO definition emphasizes acceptable limits of alcohol consumption and the appropriateness of time and place of that consumption. It takes into account the variation across cultures as to what constitutes acceptable drinking practices and focuses on the behavioral and social indicators of normal standards and social deviance. Such broad definitions tend to provide higher prevalence rates (Thoreson & Skorina, 1989).

The Diagnostic and Statistical Manual-3rd Edition-Revised [DSM-III-R] (American Psychiatric Association, 1987) emphasizes similarity between alcoholism and other forms of drug abuse. Alcoholism and alcohol abuse are included in the category "Psychoactive Substance Use Disorders," which is further subdivided into "psychoactive substance dependence" and "psychoactive substance abuse." Psychoactive substance abuse, including alcohol abuse, involves four criteria: impairment in social, occupational,

psychological or physical functioning caused by the pattern of pathological use, recurrent use of substance in situations where use is physically hazardous (e.g., driving while intoxicated), symptoms have persisted for at least one month, and person has never met the criteria for Psychoactive Substance Dependence for this substance. Substance dependence requires evidence of tolerance or withdrawal. The diagnosis of alcohol dependence requires, in addition to tolerance or withdrawal, evidence of social or occupational impairment from the use of the substance or a pattern of pathological use, and duration of at least one month. There are also five criteria for the severity of psychoactive substance dependence which include; mild, moderate, severe, in partial remission, and in full remission.

Tolerance is defined in the DSM-III-R as follows: "a need for increased amounts of the substance in order to achieve intoxication or desired effect, or diminished effect with continued use of the same amount" (p.168). Alcohol withdrawal is categorized in DSM-III-R as either "Uncomplicated Alcohol Withdrawal" or "Alcohol Withdrawal Delirium." Uncomplicated Alcohol Withdrawal is charaterized by symptoms such as:

> "...course tremor of hands, tongue or eyelids: nausea or vomiting; malaise or weakness; autonomic hyperactivity (such as tachycardia, sweating, and elevated blood pressure); anxiety, depressed mood, or irritability; transient hallucinations (generally poorly formed) or illusions; headache; and insomnia. These symptoms follow within several hours after cessation of or reduction in alcohol ingestion by a person who has been drinking alcohol for several days or longer" (p.130).

Alcohol Withdrawal Delirium is characterized by the following: "Delirium developing after cessation of heavy alcohol ingestion or a reduction in the

amount of alcohol ingested (usually within one week), marked autonomic hyperactivity, (e.g., tachycardia, sweating), and this is not due to any physical or other mental disorder" (p. 131). These withdrawal criteria are found under the category of "Organic Mental Syndromes and Disorders," along with Alcohol Intoxication, Alcohol Idiosyncratic Intoxication, Alcohol Hallucinosis, Alcohol Amnestic Disorder, and Dementia Associated with Alcoholism. These categories depict serious and grave conditions associated with excessive alcohol consumption over a prolonged period.

The diagnostic criteria for alcohol dependence or alcoholism in the DSM-III-R are relatively specific, because the pharmacological criteria of tolerance and physical dependence are clearly defined and unambiguous. The diagnostic criteria for alcohol abuse are more ambiguous than those for alcohol dependence. The category alcohol abuse includes impaired social relations with family and friends and a pattern of pathological use but may or may not include substance dependence. Professionals can fall in either or both the abuse or dependence categories without the usual public indicators of job loss, fights, absenteeism, or hospitalization for alcohol treatment that are present in other alcoholic populations (Magruder-Habib et al., 1991; Thoreson & Skorina, 1989).

Edwards (1982) offered the concept of addiction with degrees of alcohol dependence, which assumes a difference between alcohol dependence and related problems. This distinction recognizes that a person can exhibit clear symptoms of alcohol dependence without manifesting obvious public alcohol-related problems. Edwards also stresses the importance of looking at each case individually and not stereotyping alcohol abusers. He states that a "...needed skill is the development of a

discriminating judgement which is able in each case to sense out the degree of dependence, identify the rational treatment goal for that particular person, and propose the treatment fitted to that particular person's problem." (p. 23).

The classification "alcohol abuse" does not necessitate inclusion of alcohol dependence or clinical and medical problems. Mayer (1983) proposed that in order to be effective in treating alcoholism, health professionals should focus on helping alcohol abusers. He points out that most alcohol abusers hold jobs, live with families, and are reasonably healthy or at least have a good treatment prognosis. This point has significance for the treatment of psychologists and other professionals with alcohol problems. Psychologists and other professionals are more likely to be characterized by alcohol abuse than by patterns that are typical of alcoholism, because alcoholism includes the public indicators or more severe alcohol problems that tend to be uncommon among professionals until the later stages of alcoholism (Angres & Busch, 1989; Caliguri, 1989; Drogin, 1991; Harris, 1986; Lewis, 1986; Thoreson & Skorina, 1989; Westermeyer, 1988).

Vaillant (1983) has proposed that the proper assessment of alcoholism should include four basic criteria: The diagnosis should (a) imply causative factors that are independent of the presence or absence of social deviance; (b) convey shorthand information about symptoms and course; (c) be valid cross-culturally and not dependent on mores or fashion; and (d) suggest appropriate medical response to treatment. Vaillant also concludes from his longitudinal study of a sample of alcoholics that a number of alcohol-related problems, not a particular cluster, best predicts alcoholism.

A number of factors have been described that complicate the definition and diagnosis of alcoholism among professionals. Substantial stigma still surrounds alcoholism, and as a result of this stigma, psychologists strongly resist accepting their own alcohol abuse or alcoholism as a serious, life-threatening illness. Thoreson and Skorina (1989) assert that as a result in part of the stigma and in part of inclination, psychologists prefer to see their problem from an intrapsychic or a learning perspective that is subject to the control of the intellect. Another important hindrance to diagnosing alcohol abuse or alcoholism is the failure to distinguish dependency that develops from continued heavy alcohol use and its resulting medical complications from problem drinking with or without physiological dependency, but with behavioral difficulties including absenteeism, tardiness, job loss, arrests, job accidents, and fights (Thoreson, Nathan, Skorina, & Kilburg, 1983; Thoreson & Skorina, 1989).

The general public tends to define alcoholism as deviant behavior. People whose behavior is openly deviant; such as, those who exhibit public drunkenness, family disputes, violations of laws, and destructive behavior to self or others, are easily identified as alcoholics. Therefore, the small percentage of alcoholics whose behavior is markedly deviant from societal norms, or for those who exhibit demonstrable physical symptoms, the diagnosis and treatment of alcoholism is straightforward (Thoreson & Skorina, 1989). However, for the remainder of alcoholics and alcohol abusers, such as, professionals who are often not binge drinkers, hold regular jobs, and have intact families, diagnosis is not so simple. Many alcoholics are not easy to identify because their behaviors are not dangerous to society and society is ambivalent toward alcoholism. Thoreson and Skorina (1989)

postulate that in order to identify and humanely treat the professional suffering from alcohol abuse and alcoholism, it is necessary to delineate two cornerstones of ambivalence: hurt to the individual and harm to society. They further conclude that the diagnosis of alcoholism among professionals such as psychologists mandates the development of symptomatology that is appropriate to professionals. Symptoms of alcohol abuse within professional groups are far less likely to be harmful to society than they are to be harmful to the individual.

A variety of diagnostic instruments have been used for identifying alcoholics and problem drinkers, in the form of questionnaires and inventories of psychological and behavioral variables (Bissell & Haberman, 1984; Forney, Ripley, & Forney, 1988; Gerace, 1988; Goby, Bradley, & Bespalec, 1979; Larkin & McDonald, 1990; Magruder-Habib et al., 1991; Thoreson & Skorina, 1989; Westermeyer, 1988). Mayer (1983) concluded that such inventories are the most sensitive instruments for identifying alcoholism. They vary in form from those that are long and time consuming to administer to those that are brief and can be used in quick screening to assess pathological drinking practices. Moos, Finney and Cronkite (1990) report that although many clinicians and some researchers have expressed reservations about the accuracy of self-report data from alcoholic patients, reviews of the research literature on this topic suggest that, given certain conditions, self-report data are both reliable and valid. Among others, validity and reliability of self reports for alcoholics have been reported by Armor, Polich, and Stambul (1978), Sobell and Sobell (1978) and Williams, Aitken, and Malin (1985).

For the purposes of this paper, alcohol misuse is termed alcoholism. It

exists on two continua: a time continuum from early to late and a severity continuum ranging from mild to severe virulence. Consistent with Vaillant (1983) and Thoreson and Skorina (1989), it is agreed that alcoholism comes in so many guises and contains so many stages, particularly when viewed from a cross-sectional perspective, that it is not clear whether it should be conceptualized as a unitary medical problem, as a disease with wide variation in symptom patterns, as many diseases, or as many behavioral patterns. Alcoholism will be viewed, for the purposes of this paper, as both a primary disease and as a behavior disorder, defined by a multitude of previously mentioned symptoms, whose etiology is not entirely known and which may become a life-threatening illness if left untreated.

Alcoholism Among Professionals : Nature and Scope of the Problem

There has been a significant increase in public and professional attention to the topic of alcohol abuse and alcoholism in the past 20 years. Federal support of alcoholism treatment and research within the past two decades has led to advances in alcoholism treatment evaluation and new perspectives on alcoholism (Emrick & Hansen, 1983; Moos & Finney, 1983; Moos, Finney & Cronkite, 1990; Thoreson et al., 1986a, 1986b; Thoreson & Skorina, 1989). Despite the overall increase, most research on job performance and alcoholism has focused on the blue-collar worker rather than on the professional. Although there has been a great amount of interest in research and consequent new knowledge, there still remains an astonishing lack of understanding about alcoholism (Vaillant, 1983). Specific information about alcoholism among professionals is relatively scarce; however, more interest has been shown on this topic in the literature within the past decade (Angres & Busch, 1989; Anna, 1988; Bissell & Haberman,

1984; Brooke, Edwards, & Taylor, 1991; Caliguri, 1989; Drogin, 1991; Estep, Novak, & Helsel, 1989; Flynn, Sturges, Swarsen, & Kohn, 1993; Forney et al., 1988; Galanter, Talbott, Gallegos, & Rubenstone, 1990; Gerace, 1988; Harris 1986; Hurwitz, Beiser, Nichol, Patrick, & Kozak, 1987; Laliotis & Grayson, 1985; Lewis, 1986; McCrady, 1989; Pelton & Ikeda, 1991; Reamer, 1992; Skorina, Bissell, & DeSoto, 1990; Sonnenstuhl, 1989; Thoreson et al., 1986a, 1986b; Thoreson & Skorina, 1989; Westermeyer, 1988). Unfortunately, there seems to be a dearth of information regarding the alcoholic psychologist (Laliotis & Grayson, 1985; Norcross, Prochaska, & Hambrecht, 1991; Skorina et al., 1990; Thoreson, Budd, & Krauskopf, 1986a, 1986b; Thoreson et al., 1983; Thoreson et al., 1989; Thoreson & Skorina, 1989).

The studies that have been done and the attention that the topic of alcoholism among professionals has received stems from two professional and humanitarian concerns: (1) the responsibility of the professions to set standards for professional practice and ethical conduct, and (2) to care for those members of the profession who are themselves suffering from a disease that is often career-threatening and fatal (Thoreson et al., 1983; Thoreson & Skorina, 1989).

The increased attention on the negative effects of alcohol abuse on performance in the health professions and in other high-status, high-visibility groups has led to increased public awareness of the harmful effects of alcoholism and to the need for programs to help professionals who suffer from alcohol problems. Such programs include efforts by the professions and by recovered alcoholics within the professions to extend help to colleagues. Formal treatment and self-help programs for distressed or impaired professionals have been developed for lawyers, dentists, nurses, social

workers, physicians, pharmacists, clergy, airline aviators, veterinarians, psychologists, and other professional-executive groups (Angres & Busch, 1989; Bissell & Haberman, 1984; Caliguri, 1989; Drogin, 1991; Flynn et al., 1993; Galanter et al., 1990; Larkin & McDonald, 1990; McCrady, 1989; Pelton & Ikeda, 1991; Reamer, 1992; Sonnenstuhl, 1989; Thoreson et al., 1983; Thoreson & Skorina, 1989). Treatment and intervention for professionals will be discussed later in this review.

Thoreson, Budd and Krauskopf (1986a) report that most research on job performance and alcoholism has concentrated on the blue-collar worker rather than on the professional. The authors highlight the irony that "... it is the white collar professional worker with alcohol problems in whom industry and other work sectors have a major investment, whose alocholism constitutes a substantial cost to both industry and society, and for whom intervention and treatment can result in a significant gain in return to normal work function. It is also estimated that the greatest incidence of problem drinking occurs during what are considered the most productive years (35-55 years old) of professional-executive employees and that such problem drinking employees tend to be valued employees who have worked for the same company for an average of 14 to 20 years" (p. 211). Bissell and Haberman (1984) provide a comprehensive review of the impact of alcoholism among professionals, particularly among physicians, nurses, dentists, psychologists and other health care professionals. Thoreson, Nathan, Skorina, and Kilburg (1983) reviewed preliminary efforts in psychology to reach distressed psychologists. Thoreson, Budd, and Krauskopf (1986b) and Skorina, Bissell, and DeSoto (1990) took a closer and more focused look at alcoholism among psychologists. Later in this review, these

studies specifically pertaining to psychologists will be discussed in more detail.

Various factors present in the work environment have been suggested to explain the limited information on alcohol problems among professionals. Some of these are as follows: the lack of objective performance standards and performance evaluation, performance standards that are unenforced, self-regulatory professsions (work is evaluated by peers and workers are more autonomous), low visibility of job performance, minimal supervision, the limited social distance between the supervisors and professional-executive employee, impairment of job performance that is subtle and not readily noticeable, the "social control" imposed on professionals and executives (within which thoughtful, prudent behavior is rewarded, and rash, impulsive behavior is punished), subordinates tendency to protect rather than to confront high-status superiors who have alcohol problems, and colleagues who enable the alcoholic to continue in harmful drinking patterns without intervening in some way (Drogin, 1991; Gerace, 1988; Thoreson et al., 1983, Thoreson et al., 1986a, 1986b; Thoreson & Skorina, 1989).

The concept of alcohol dependency seems to characterize professionals and executives who tend to abstain from deviant behavior and encourage control. They are more likely to engage in daily drinking by spacing drinks, which serves the dual function of maintaining a moderately elevated blood-alcohol level to create a sustained high while controlling the obvious behavioral indicators of drunkenness. Socially deviant behavior such as open intoxication, arrests, belligerence, and job loss are rarely found in professionals with problems of alcohol abuse. These chief symptoms of

alcoholism tend to be more accepted and tolerated among male blue-collar employees. For female employees at all social and work levels, drunkenness appears to be condemned and drinking is hidden. Professional women are at risk for developing alcoholism as a result of denial (Thoreson et al., 1986a; Thoreson & Skorina, 1989).

Gerace (1988) found in her study of 160 nurse educators, most of whom were females, that consumption patterns of this sample differed from normative drinking patterns of women in general. Escape drinking correlated significantly with both higher consumption and problem drinking. It was also noted in this article that frequency of drinking and volume of consumption increase with educational background. Employment status also significantly predicts alcohol consumption in women, that is, frequency of drinking is higher among employed women than among those who are unemployed. It was also suggested that the stress women feel in combining employment with family responsibilities is an antecedent to problem drinking in women. Gerace concludes that their status as educated, employed women may increase the risk for alcohol abuse in nurse educators. It would be interesting to study alcoholism among female psychologists to see if there are parallels to Gerace's study in drinking patterns among educated women.

There has been much speculation about occupational differences in drinking patterns and evidence seems to confirm differential risk factors among occupations. Some have studied the drinking practices of various occupational groups including nurses, lawyers, military health-care personnel, physicians, university professors, psychologists, and anesthesiologists. There are risk factors that are similar among various

professional groups and factors that appear to be unique to a specific professional group. Whether it be the emotional and financial stressors of medical school, the high pressured and competitive atmosphere of being a trial lawyer, the major responsibility of being an airline pilot, the isolation of research and writing for the university professor, or the multiple hazards of being a clinical psychologist, the variety of risk factors are well documented (Anna, 1988; Brooke et al., 1991; Caliguri, 1989; Drogin, 1991; Flynn et al., 1993; Gerace, 1988; Guy, 1987; McCrady, 1989; Pelton & Ikeda, 1991; Skorina, Bissell, & DeSoto, 1990; Thoreson et al., 1983; Thoreson et al., 1986a, 1986b; Thoreson, Miller, & Krauskopf, 1989; Thoreson & Skorina, 1989). For the purposes of this review, risk factors and/or antecedent events that may increase the probability of alcohol problems among professionals will be discussed as they pertain to or are similar to the alcoholic psychologist.

The fact that alcohol abuse is relatively hidden among professionals presents a major problem in the detection and determination of the nature and extent of alcohol abuse and alcoholism in the professions. Several factors, some of which have been mentioned previously in this review, make identification difficult. One of these is the cultural and/or societal variations in alcohol use patterns and beliefs concerning what constitutes alcohol abuse among different social classes and occupational groups. Further, alcohol abuse among professionals presents a unique dilemma in that the tangible indicators of alcoholism are usually not apparent until relatively late in the addiction process. The drinking patterns of most professionals are characterized by control, and the symptoms of alcoholism among professionals are more internal than external. The more obvious external symptoms and deterioration in social relations, work behavior, and

appearance are generally not evident, despite the probability that the alcoholic professional experiences the intense suffering and pain found in other groups (Thoreson & Skorina, 1989; Thoreson et al., 1983).

Thoreson and Skorina (1989) identified risk factors in the work environment and specific characteristics of professionals that merge to sanction alcohol abuse and indicated that these factors appear to have direct relevance to psychologists. The twelve points that illustrate risks in the professional work environment and characteristics of professionals that complicate the identification of alcohol abuse and alcoholism are as follows:

1. *Role bifurcation.* In role bifurcation, the individual has both a professional and an institutional identification. This dual identity, which requires a major investment of time and energy by the professional in extracurricular and off-job-site meetings, leads to much hidden time away from the work setting in socially sanctioned, high-drinking environments (e.g., conventions, vacations).

2. *Tenure and academic freedom.* These safeguards for the academic, which have their counterpart in nonprobationary status in most state and civil service professional positions, also provide the opportunity to drink abusively. The nature of professional work involves autonomy and minimal accountability for performance to peers or supervisors. Thus, autonomy and freedom from interference, which are vital and indigenous to both professional and academic practice, enable alcohol abuse to flourish.

3. *The high esteem bestowed upon professionals.* Professionals are given "idiosyncrasy credits" for behavior that can be symptomatic of alcohol abuse. Attitudes such as arrogance, aloofness, impatience,

agitation, and irritability, and behaviors such as missed appointments, missed classes, and time away from the office, tend to be accepted and sanctioned as evidence of eccentricity and as essential attributes of the lonely scientist/scholar.

4. *Subordinate-status dependency and isolation*....the independent position of the academic professional is paradoxically characterized by a subordinate status and sense of dependence, separateness, and alienation from society. Psychologists often spend a good deal of time in solitary work performance. It is typical of those in private practice to function with minimal or no supervision and limited contact with other professionals. For many professionals, a substantial part of their job is inevitably an unchallenging, lonely one that places frustrating limits on creativity and accomplishment. Thus, boredom, frustration, and isolation exist that are conducive to alcohol abuse.

5. *The committment to discovery and expanded awareness.* Psychologists as scientists are committed to discovery and altering awareness to achieve new perspectives. Consequently, the use of mind-altering drugs and alcohol in the pursuit of such perspectives is common among professionals, artists, and poets. This tendency is confirmed in a study by Thoreson, Budd and Krauskopf (1986b) who found that alcoholic psychologists in abstinence-based recovery reported substantial use of mind-altering substances in addition to alcohol during their active drinking days. Slightly over 40 percent of the sample reported having used stimulants, such as amphetamines, and psychodelics, such as LSD, mescaline, or marijuana.

6. *Denial.* Denial is one of the diagnostic canons of alcoholism.

Alcoholism is the only disease that does everything to inform the patient who has it that she or he does not have it.... the alcoholic psychologist tends to replace the external reality of her or his alcoholism with a wish-fulfillment fantasy of control and nonimpairment or potency. The myth of invulnerability, ...serves to increase the magnitude of resistance and of the denial of alcohol problems.... psychologists with serious alcohol problems sincerely believe in their ability to control and solve problems. Their intellectual pride and feeling of omnipotence constitute powerful obstacles to admitting failure. Psychologists tend to look upon their inability to control alcohol misuse as a major failure, a form of narcissistic injury. One of the morbid fears of psychologists in a clinical practice is that they may become impaired in the same way that their clients or patients are impaired. The counterpart for the academic psychologist resides in the panic that goes with the thought of becoming unknowledgeable and thus comparable to students. Pride, as it relates to this narcissistic injury, has its origin in the shame surrounding lack of control over alcohol. When we fail to live up to what we believe a professional should be (positive ego ideal) and become failures, or what a professional should not be (negative ego ideal), we develop an overwhelming sense of worthlessness. Denial is used by the alcoholic professional as a means of escaping these intense feelings. Denial, then, for many alcohol abusers or active alcoholics, becomes the means of controlling an uncontrollable situation. The use of selective attention and inattention serves as a defense against shame and reinforces the belief system that nothing is wrong.

7. *The myth of power and invulnerability.* This myth, which is

characteristic of most scientists and academics and is critical to the scientific enterprise, has the adverse effect of reinforcing the irrational belief that professionals can, solely through the use of their intellectual resources, solve all personal problems. This denial of essential limitations is a major problem for individuals who are trapped in alcohol addiction (Kurtz, 1979, 1982). Kurtz argued that refocusing on vulnerability and accepting human limitations is essential to recovery and to comfortable living without the use of chemicals. Many professionals are firmly committed to the belief that achievement denotes power and control and that competency prevents alcoholism. Such professionals who are caught in the web of alcohol abuse have particular difficulty focusing on "essential limitations of being." Yet according to Kurtz, it is precisely in this acceptance of essential limitations that professionals can come to terms with their problems of alcohol abuse.

8. *Difficulty in accepting the intractable nature of alcoholism.* Alcoholism is a deeply imbedded, intractable, long-term pattern of behavior that cannot be overcome by conscious, deliberate effort. This fact seems especially frustrating and antithetical to the pedisposition and training of psychologists as scientists. The training of psychologists predisposes them to a commitment to behavioral change and learning. The professional-scientist is also characterized by high internal controls. These traits complicate the acceptance of a deeply imbedded, intractable habit or disease. The beliefs in the possibility of behavioral change and in the capacity to solve problems for self and others are strongly reinforced and indigenous to the scientific community. Therefore, it is

not surprising that psychologists generally prefer intrapsychic or learning-behavioral concepts of alcoholism to the disease model (Bissell & Haberman, 1984; Moos & Finney, 1983; Peele, 1984; Thoreson et al., 1983).

9. *The proclivity to self-treat.* The professional psychologist with a serious alcohol problem is likely to attempt by his or her own resolve to change behavior and cognitions in order to solve the alcohol problem. This effort is likely to fail. The deeply imbedded alcohol abuse resists definition, data collection, and data analysis and makes it unlikely that the psychologist can come to conclusions about the problems. The perceived need for change is convoluted and the power of denial and rationalizations so imbedded in the habit of alcohol misuse that grossly inaccurate conclusions about behavior are reached that do not lead to a commitment to change. The result is that the denial system becomes even more firmly established, such that the psychologist may ignore or be completely unaware that his judgment is impaired. Johnson (1980) suggested that impaired judgment, by definition, excludes self-perception of impairment.

Despite objective evidence of lack of success, psychologists are likely to engage in self-treatment to solve their alcohol problems. Seeking out treatment from another professional is difficult, for this necessitates relinquishing control and accepting the likelihood that change without help from others is not possible. One vehicle that is often used for self-treatment is medication. Psychologists may self-medicate with drugs or alcohol. The retrospective study by Thoreson et al. (1986b) of alcoholic psychologists in abstinence-based recovery provided clear

evidence that during active drinking, psychologists used a wide variety of prescription and nonprescription drugs. On the other hand, professionals may also use behavioral change strategies to change belief systems regarding their pathology ("it is not so bad") or may use other behavioral approaches to change actual behaviors (when, where, or how they ingest alcohol) in an attempt to gain control over their drinking. Because obsession with control, rather than loss of control, tends to be the key characteristic of professionals with severe alcohol problems, the latter is a likely alternative.

10. *The confounding of high achievement and alcoholism.* Many alcoholic psychologists tend to be high achievers in their fields,...but because a modest performance level is often set for job performance, those impaired by alcohol abuse can drop off considerably in productivity and still be viewed as performing satisfactorily, albeit marginally, in their work. On the basis of clinical observation and research, Bissell and Jones (1976) reported high performance for professionals.... In addition, assessing the performance is further complicated by the difficulty in separating out the alcohol-impaired performance from the natural tailing off of performance due to aging.

11. *Overcompensation.* The tendency to overcompensate as a means of hiding an alcohol problem is particularly prevalent during the middle stages of alcoholism. Appropriate and timely intervention may be hampered if the professional continues to perform at a high level, possibly in a more limited and narrow area of the job. Frequently this area of performance is quite visible to colleagues and superiors and diverts their attention from signs of alcohol misuse in the professional's

job performance (Thoreson et al., 1983).... In the late stages of alcoholism, obvious decrement in job performance is likely to be apparent, whereas impairment in interpersonal and, particularly, family relationships is obvious at earlier stages.

12. *Infrequent sanctions.* Bissell and Haberman (1984) reported that although approximately 60 percent of their sample of physicians with alcohol problems were admonished about their drinking by colleagues and approximately 25 percent of those physicians were warned by their employers or the professional medical society and lost hospital privileges, alcoholic physicians were rarely fired during their drinking days.... Although internal indicators of despair are likely and a variety of external indicators of job decline are noticeable to both the alcoholic professional and to his or her colleagues, threats of sanctions and actual job loss are infrequent, and when they do occur, the alcohol misuse has progressed to the latter stages of alcoholism, where serious irreparable damage may have occurred. (pp. 88-92).

The Prevalence of Alcoholism Among Professionals

Alcoholism is the third leading cause of death in the United States, affecting an estimated 10 percent of those over sixteen years of age, or roughly 18 million people (Drogin, 1991; Moos, Finney & Cronkite, 1990). Survey research suggests that approximately 70 percent of Americans drink and that more than 90 percent of college-educated people drink. The Department of Health, Education, and Welfare estimated than between 9.3 and 10 million people, or 7 percent of the population, could be considered problem drinkers. Of these, approximately 6 percent to 10 percent develop alcoholism (Bissell & Jones, 1976; Magruder-Habib et al., 1991; Thoreson et

al., 1986a; Thoreson & Skorina, 1989). Estimates of alcoholism among various health professions lean toward the upper end of this range despite low anticipated rates for professionals considering cultural and demographic characteristics (Thoreson et al., 1986a).

The general population's lifetime prevalence rate of alcoholism has been estimated as high as 11 to 16 percent (Flynn et al., 1993). More than four times as many men as women have been noted to be alcoholics (Bissell & Jones, 1976; Efron et al., 1974). Gerace (1988) and Bissell and Haberman (1984) report that the general incidence of alcoholism is estimated at 10 percent for men and 5 percent for women. However, the question as to whether women are less prone to alcoholism than men has not been satisfactorily answered at this time. It may be that women are less identifiable (Gerace, 1988).

A review of the literature on incidence of alcoholism among professionals revealed a lack of reliable data on the numbers of people in the professions affected by alcoholism or drug dependency. Most figures were estimates based on data from treatment groups, medical record reviews, self-report questionnaires, or on guesses from clinical experience (Brooke et al., 1991; Bucholz et al., 1992; Drogin, 1991; Larkin & McDonald, 1990; Thoreson et al., 1986a; Thoreson & Skorina, 1989).

Laliotis and Grayson (1985) reviewed estimates of impairment of physicians due to alcoholism, drug dependency, or major psychiatric illness and found that prevalence rates reported in various studies ranged from 5 percent to 15 percent. Angres and Busch (1989) report that some estimates for the prevalence of chemical dependence among physicians have been as high as 40 percent. It has also been suggested that the overall prevalence of

dependence on drugs or alcohol among physicians may not be different from that of the general population (Angres & Busch, 1989; Brooke et al., 1991; Larkin & McDonald, 1990).

In a survey of 195 medical trainees at the University of Minnesota, Westermeyer (1988) found that alcohol was the second most used substance. Of this sample, up to 47 percent acknowledged pathogenic drinking practices (e.g., to fall asleep, to relieve anxiety, to be more sociable) and up to 20 percent admitted to pathological drinking (e.g., amnesia while drinking, car accident while drinking). Conversely, in a study of 215 medical interns and residents of British Columbia, Hurwitz et al. (1987) found that alcohol or other substances were infrequently used as coping responses (5 % and 2% respectively). In addition, Brooke et al. (1991) found that alcohol was the current problem for 41.6 percent of their sample of 144 doctors from a London postgraduate hospital who had received treatment for drug and alcohol dependency. However, they also cited a longitudinal study of 1117 white male physicians that found less than 1 percent to have had alcohol-related problems.

Drogin (1991) describes alcoholism in the legal profession and reports that the national rate of alcoholism among lawyers may run as high as 15 percent. He concludes then that over 80,000 persons out of the legal community of 543,000 are alcoholics. Estimates for alcoholism and drug abuse among dentists range from 20 to 30 percent (McCrady, 1989; Thoreson et al., 1986a). Alcoholism among airline aviators is reported to be approximately 12 percent (Flynn et al., 1993). Larkin and McDonald (1990) report that the American Nurses Association estimates that six to eight percent of their 1.9 million registered nurses are addicted to drugs and/or

alcohol, and that the Georgia Impaired Physicians Program puts that figure at 13 to 17 percent for both physicians and nurses. Elliott and Guy (1993) revealed that 7.1 percent of their sample of 340 female mental health professionals reported a history of substance abuse.

The actual prevalence of alcoholism among psychologists is very difficult to estimate. However, in a survey study by Thoreson, Miller and Krauskopf (1989), 9 percent of the members of a state psychological association were self-reported problem drinkers. Thoreson et al. (1983) and Thoreson and Skorina (1989) selected 6 percent as a reasonable estimate of the rate of alcoholism among those in the profession of psychology, and state that it is likely that the incidence is higher for male than for female psychologists. They encouraged establishing an "incidence band" rather than a rate for alcoholism within the profession of psychology. Thoreson and Skorina (1989) more specifically proposed the following:

> The lower portion of the band would show incidence rates of approximately 6 percent for men and 3 percent for women. The higher portion of the band would show rates of 9 percent for men and 4 percent for women. On the basis of 100,000 PhD-level psychologists in the United States and a male-female ratio of 2 to 1, we could extrapolate these totals: 7,000 psychologists (5,800 males, 1,400 females) at the high prevalence level, and 4,950 psychologists (3,900 males, 1,050 females) at the lower prevalence level (p. 87).

The critical factor is not to estimate the exact number but to realize that a substantial number of psychologists suffer adverse consequences due to alcohol abuse, including work-related impairment (Thoreson et al., 1986a; Thoreson & Skorina, 1989). Laliotis and Grayson (1985) highlight an

important point in that professionals (including psychologists) cannot afford to ignore the need of their impaired colleagues, however small their numbers.

According to Thoreson and Skorina (1989), prevalence rates are typically determined from several diverse methodologies. The most common are: (a) the Jellinek revised estimation formula, in which estimates of the number of alcoholics are based on number of deaths each year due to cirrhosis of the liver; (b) the Schmidt and DeLindt formula, which is similar to the Jellinek formula and is also based on deaths due to cirrhosis of the liver; (c) the Schmidt and DeLindt suicide formula, which estimates the number of alcoholics alive in a given year from the number of suicides; and (d) the Marden age/sex matrix, which estimates the number of problem drinkers on the basis of prevalence in various population subgroups. Bissell and Haberman (1984) concluded in their report of alcoholism among professionals, that there are no accurate estimates of prevalence rates of alcoholism among specific professional groups at this time. The literature specific to certain professional groups, such as, physicians, lawyers, airline aviators, dentists, psychologists and other health professionals concur that accurate prevalence rates of alcoholism do not exist at this time (Brooke et al., 1991; Drogin, 1991; Flynn et al., 1993; Larkin & McDonald, 1990; McCrady, 1989; Skorina et al., 1990).

Bissell and Haberman (1984), Laliotis and Grayson (1985), and Thoreson et al. (1983) all agree that at present no reliable studies exist on the prevalence of alcoholism among members of professional groups. Current prevalence rates for professionals are based on data provided by disciplinary groups, impaired-physicians committees, impaired-attorney

committees, and so on. These groups report on numbers that are brought to their attention; however, the sampling that is reported is selective, so there is no valid way to extrapolate to a general incidence for the professions (Thoreson & Skorina, 1989). Bissell and Haberman (1984) were convinced, however, that the alcoholism rate among physicians is probably higher, not lower, than reported. They based their conclusions on medical data that has shown that physicians have a high mortality rate from cirrhosis of the liver (3.5 times that of the general population). Bissell and Haberman concluded on the basis of an "exhaustive literature review" that they cannot say "with any degree of certainty how many members of any major profession already are or will become alcoholic" (p. 28). Despite the great amount of statements on the incidence of alcoholism and alcohol abuse among professionals, the true incidence of alcohol abuse and alcoholism remains a mystery. Determination of exact rates appears to be infeasible because estimates are a function of both particular methods and the definition of alcoholism (Thoreson & Skorina, 1989).

Treatment of Alcoholism for Professionals

Issues concerning the provision of alcoholism treatment to professionals are currently receiving major attention in the literature (Angres & Busch, 1989; Bissell & Haberman, 1984; Bissell & Jones, 1976; Flynn et al., 1993; Goby et al., 1979; McCrady, 1989; Moos, Finney & Cronkite, 1982, 1990; Pelton & Ikeda, 1991; Skorina, 1982; Skorina et al., 1990; Thoreson et al., 1983; Thoreson et al., 1986a, 1986b; Thoreson & Skorina, 1989; Van Den Bergh, 1991). Alcoholism is one of the major health problems of our society (Efron, Keller & Gurioli, 1974), and chemical dependency has been noted as the major cause of decline in performance among

professionals (Thoreson & Skorina, 1989). The annual cost of alcoholism-related health care services is estimated to be more than $15 billion, and alcoholism treatment services have increased twentyfold in the United States from 1942-1976 (Moos, Finney & Cronkite, 1990). Failure to recognize and diagnose alcoholism in professionals means that their recovery is delayed, and they may not recover at all (Skorina, Bissell & DeSoto, 1990). Researchers have found that professionals, including psychologists, rarely receive formal intervention from or attain recovery through actions of colleagues (Bissell & Haberman, 1984; Thoreson, Budd & Krauskopf, 1986a, 1986b; Thoreson et al., 1983; Thoreson & Skorina, 1989).

Concern for the human problems of employees dates back more than forty years to the establishment of the first Occupational Alcoholism Programs in industry. Today, the vast majority of Fortune 500 companies have active Employee Assistance Programs, designed to provide a constructive alternative to job action for employees whose work performance is impaired because of personal problems (McCrady, 1989; Van Den Bergh, 1991).

Humane attention to the problems of professionals dates back twenty years, as marked by the American Medical Association's Council of Mental Health report on "The Sick Physician." Following that report, concern for the impaired or distressed professional has increased exponentially, and currently many of the major professions have formal or grassroots programs to assist members of their profession who are unable to function fully because of personal problems related to substance abuse or emotional, family or physical problems (McCrady, 1989; Thoreson & Skorina, 1989).

There has been a revolution in approaches to the distressed or

impaired professional in the last twenty years. Professional societies and professional licensing boards have begun to acknowledge the problem, and have developed programs to assist impaired professionals to recover, rather than be punished. Individual professionals who have recovered from personal problems (usually alcohol or drug abuse) have also been concerned about their colleagues, and have developed programs to assist others in their profession. These two different approaches, impaired professionals helping their colleagues, and formal programs sponsored by the state society or licensing board, have somewhat different philosophies. These programs tend to vary on the continuum of voluntary to coercive features (McCrady, 1989; Thoreson & Skorina, 1989). Thoreson and Skorina (1989) specify that the programs at one end of the spectrum are strictly voluntary and keep no records, whereas programs at the other end use a more assertive outreach approach whereby uncooperative physicians are offered a choice of treatment or a loss of licensure. The majority of programs fall somewhere between these two extremes.

A review of the literature reveals a number of alcoholism treatment programs that have been developed for various professional groups including physicians, lawyers, medical students, airline aviators, dentists, nurses, psychologists, and other health care workers. (Anna, 1988; Drogin, 1991; Flynn et al., 1993; Larkin & McDonald, 1990; McCrady, 1989; Pelton & Ikeda, 1991; Thoreson et al., 1986b; Westermeyer, 1988). The initial reports of the treatment programs' effectiveness are encouraging. The California Physicians Diversion Program reports an overall success rate of 73 percent (Pelton & Ikeda, 1991), the United Airlines alcoholism treatment program reveals that 87 percent of their treated airline pilots successfully worked the

program and were allowed to return to flight duties (Flynn et al., 1993), and McCrady (1989) cites several studies with physicians who completed a treatment program showing success rates ranging from 67.5 percent to 93 percent. Although these percentages are encouraging, it is difficult to define exactly what constitutes "success" in these studies. Each study varies in their criteria for success rates.

Laliotis and Grayson (1985) provided a historical perspective on the efforts in various professions, particularly in medicine, to establish programs for impaired professionals. They noted that all 50 state medical societies have established impaired-physicians' committees to deal exclusively with the problem of impairment, including the problem of alcohol abuse. The committees vary in how they handle the problem of impairment, the extent to which they are involved in treatment facilities, and their relationship to the state examining board. Bissell and Haberman (1984) provided an extensive review of efforts currently underway in the professions to help colleagues with alcohol problems, and summarized efforts in other health professions in our society, including osteopathic medicine, dentistry, nursing, the legal profession, social work, and psychology. They concur with Laliotis and Grayson (1985) that state efforts vary considerably in level of activity and in degree and also noted considerable variation in quality.

Laliotis and Grayson (1985) confirmed a reluctance on the part of professions, particularly psychology, to become involved in programs for their distressed members. In their survey of activities of state psychological associations regarding efforts to help distressed psychologists, they concluded that state associations have done little to assist colleagues. They found that although a number of states were in the process of developing

programs for impaired psychologists, no programs for impaired psychologists were in operation at that time. A number of responses to their request indicated complete ignorance of the problem. Laliotis and Grayson suggested several alternative explanations: (a) denial (it is easier to see impairment elsewhere rather than in oneself); (b) the existence of more pressing issues; (c) the relatively recent attention to consumer rights; and (d) possible low incidence of reported alcohol problems.

A reluctance to admit to difficulties constitutes a deterrent to treatment and is a basic part of the role and function of high-status executives and professionals (Thoreson & Skorina, 1989). Thoreson, Budd and Krauskopf (1986a) reporting on a survey of perceptions of alcohol problems among psychologists found that few psychologists are confronted for alcohol problems, and of the few who are confronted, even fewer seek help or treatment. This finding stands in stark contrast to the view of alcoholism held by the same psychologists who responded to the study, that alcoholism is a relatively permanent and severe affliction with discernable adverse consequences for work, interpersonal relationships, and family relationships.

Although psychologists are unlikely to be confronted for alcohol problems or to seek help for it, they are, however, likely to seek help from psychologists or psychiatrists for mental health or personal development (Thoreson et al., 1983; Thoreson et al., 1986a; Vaillant, 1983). As suggested by Thoreson et al. (1986a) the stigma remains a major deterrent to help-seeking behavior by professionals for alcohol problems, because their reputation and earning capacity could suffer.

Support advocacy groups consisting of recovered alcoholics have

recently come into view to help colleagues in distress. Such support groups are found in the professions of law, medicine, dentistry, nursing, social work, and psychology (Bissell & Haberman, 1984; McCrady, 1989; Skorina et al., 1990; Thoreson et al., 1983; Thoreson et al., 1986b; Thoreson & Skorina, 1989; Westermeyer, 1988). Many of these self-help groups are modeled on the principles of Alcoholics Anonymous (AA), which has been suggested as an important resource for executive-professionals with problems of alcohol abuse and alcoholism. AA support goups constitute for many alcoholics an important component of long-term recovery. The two most prevalent approaches in the field of alcoholism treatment are group psychotherapy and referral to Alcoholics Anonymous. AA appears to be a significant posttreatment support system for many alcoholics, including psychologists, and can help prevent relapse (Armor, Polich & Stambul, 1978; Bucholz et al., 1992; Chappel, 1992; Grunberg, 1992; Thoreson et al., 1986b; Thoreson & Skorina, 1989; Van Den Bergh, 1991). Either peer groups (60% abstinent) or job-based (74% abstinent) treatment groups demonstrate the highest rate of non-relapse for males working in general industry. Additionally, the goal of abstinence from alcohol rather than "modified drinking" provides the highest chance for non-relapse (Flynn et al., 1993). It has been estimated that in the United States there are 500,000 support groups attended each week by 15 million Americans, and in the last ten years the number of self-help organizations has quadrupled (Van Den Bergh, 1991). Alcoholics Anonymous currently has an estimated worldwide membership of 1,551,228, with 835,489 members and 40,693 groups reported in the United States (Grunberg, 1992).

Self-help groups have been the trend of the 1980s. Van Der Avort

and Van Harberden (1985) described the process of mutual identification that encourages each member to relate to his or her own experience. They referred to the major element in self-help groups as mutual identification or "identification resonance." They also identified four values that play a major role in self-help groups: self-determination, authenticity, hope, and solidarity, in addition to the central characteristic, which is the gaining of experiential knowledge.

Thoreson and Skorina (1989) point out that members of self-help groups frequently develop attitudes that conflict with professional training. These include an emphasis on affection, appreciation of personal experience, common sense and intuition, direct responsibility and self-assistance, emphasis on spontaneity, and practical problem solving. They go on to say that, "These elements, considered to be critical to the maintenance of sobriety via the Alcoholics Anonymous programs, are of importance to the alcoholic professional...Perhaps of more fundamental significance is the discovery that people can help and forgive each other while at the same time reacting with competence and compassion" (p. 95).

Bissell and Haberman (1984) have described four stages in the development of efforts in the professions to help their alcoholic members: (a) Professionals deny the problem and extrusion of noticeably impaired persons, (b) alcoholic individuals in the profession struggle, enter into recovery, and finally seek affiliation with Alcoholics Anonymous as a posttreatment support system, (c) professionals in AA establish self-help advocacy within the profession, and (d) these professionals advocate increased problem awareness and outreach programs for members of the profession who are distressed by alcohol and other major health problems.

This advocacy results in programs to assist distressed professionals.

As discussed by Skorina (1982), Thoreson et al. (1983), and Thoreson and Skorina (1989), a similar sequence was seen in psychology. In addition to the American Psychological Association's (APA) formal efforts to address the general problem of distressed professionals, a group of psychologists developed an organization, Psychologists Helping Psychologists (PHP), to provide support for alcohol-impaired colleagues. The initial planning efforts for PHP began in the fall of 1980. The efforts were patterned after research on impaired physicians, social workers, and nurses.

An initial committee focused on common needs and interests in creating an advocacy-support group for psychologists. In 1981, fourteen recovering alcoholic psychologists met in Rhode Island to discuss the establishment of a volunteer organization to help other psychologists like themselves who might be in various stages of recovery from alcoholism. It was there that Psychologists Helping Psychologists was founded. The planning group believed that PHP could provide an opportunity for recovered psychologists to share, in the language of AA, their "experience, strength, and hope." Planning committee members, all in recovery from alcoholism, found that their initial denial seemed to have been a major sign of their alcoholism. The committee recognized that psychologists, committed to a belief in their capacity to control behavior, affect behavioral change, and solve human problems, were reluctant to ask for help for alcohol problems. The combination of scientific skepticism, intellectual pride, and feelings of invincibility constitute a powerful barrier to identification and treatment of alcoholism among psychologists. The members found a need for mutual support that led to the planning and formation of PHP (Skorina, 1982;

Thoreson et al., 1983; Thoreson & Skorina, 1989).

Membership in PHP is open to alcoholic or drug-dependent doctoral-level psychologists (including doctoral candidates) who are interested in sharing their experience, strength, and hope with one another to improve the quality of their sobriety. Members are interested in helping colleagues, conducting research, and educating peers about experiences with alcohol and drugs, because PHP members believe that the psychology profession has failed to provide adequate training regarding this impairment. Psychologists Helping Psyhologists is an international organization with membership from all over the United States, Canada, and Australia. Psychologists hear of the association by word of mouth and through ads placed in the State Organization newsletters. The treatment goal of PHP and its members is abstinence. PHP members constitute a significant resource for other psychologists who are in abstinence-based recovery from alcoholism and substance abuse (Skorina, 1982; Thoreson et al., 1983; Thoreson & Skorina, 1989).

Bissell and Haberman (1984) have summarized the special issues, promise, and difficulties that have been encountered in developing and implementing programs that protect clients' rights as well as members of the profession in cases of alcohol abuse. Despite the difficulties, Thoreson and Skorina (1989) warn that, "The one action that is certain to be wrong is to do nothing, ignoring the problem until it becomes a major deterrent to practice and is dangerous to both the professional and to users of professional sevices" (p. 96).

Thoreson and Skorina (1989) discuss the debate of abstinence versus controlled drinking and the implications of both for treatment of alcoholism.

They conclude that, with the exception of a relatively small category of "early problem drinkers" and persons who misuse alcohol but have not yet become physiologically dependent, abstinence— not controlled drinking— represents the optimal solution for recovery from alcoholism. Further, they reiterate the fact that alcoholism is both a learned behavior and a chronic disease-like, medical condition regardless of which side of the debate is favored.

While the controversy continues, many people with severe alcohol problems die. Death may result from accidents, particularly auto accidents, from illnesses such as cirrhosis or pancreatitis, from malignancies related to the toxic effects of alcohol, from suicide, as well as from the same physical illnesses that kill everyone else but are exacerbated by alcohol abuse. Clinical evidence suggests that alcoholics die younger and at a higher rate— two to four times that of nonalcoholics (Moos, Finney & Cronkite, 1990; Rich, Ricketts, Fowler & Young, 1988; Roy & Linnoila, 1986; Vaillant, 1983). Vaillant's (1983) 8-year follow-up study of alcoholics found that people with severe alcohol problems appear to move toward abstinence or toward a premature death, but only rarely to a successful controlled drinking pattern. This model is supported both by the AA self-help position and by the conventional wisdom regarding the need for abstinence (Thoreson & Skorina, 1989).

Thoreson and Skorina (1989) report that those who represent the alcohol treatment community concede that some people do manage to stop drinking on their own. Some problem drinkers, typically those in the early stages without physiological dependency and with environmental resources, are able to return to social or controlled drinking. For the most part,

however, those with severe alcohol problems require abstinence and outside assistance in order to cope effectively with their alcohol problems.

Vaillant (1983) presented a convincing case that psychotherapy is remarkably ineffective as the treatment for active alcoholism. In his Harvard sample, 26 subjects with severe alcohol problems had received a combined total of 5,000 hours of psychotherapy. Of these 26, only 2 ever attained sobriety, and one of these 2 relapsed and became a member of AA. According to Thoreson and Skorina (1989), those with severe alcohol problems will do anything to solve their problems except not drink; therefore, psychotherapy, be it dynamic or behavioral, with persons who have severe alcohol problems and who continue to drink abusively is likely to be at best ineffective and at worst harmful to the alcohol-abusing professional. Thoreson and Skorina concurred with Vaillant but offered this important exception: "Psychotherapy conducted with individuals in abstinence-based recovery, as opposed to those in active alcoholism, is very useful as an aftercare support. It permits the client to work toward uncovering persistent and unproductive patterns of behavior, to develop problem-solving behaviors, to gain a new understanding of internal dynamics, and to acquire a set of strategies to prevent relapse" (p.98).

Thoreson, Budd and Krauskopf (1986b) emphasized the importance of Alcoholics Anonymous as a posttreatment aftercare resource for psychologists. They revealed that a sub-sample of alcoholic psychologists in abstinence-based recovery had relied heavily on AA as an aftercare resource and reported a minimal amount of relapse and a considerable amount of sustained sobriety. Over 90% of the sample were in abstinence-based recovery through AA. The average length of sobriety of this subgroup was

approximately 5 years, and more than 60% of the sample reported no relapse since they first sought AA for help. The importance of AA was supported by Edwards (1982), who recommended that AA be routinely offered when an abstinence goal has been selected.

Thoreson and Skorina (1989) believe that it is critically important to give careful attention to the ethical and moral dilemmas of the current approach to treating alcoholism. This includes maintaining an openness to the limited state of knowledge and examining both clinical and research findings in developing a coherent and defensible treatment strategy for psychologists with severe alcohol problems. Edwards (1982) offered several recommendations that may help in this endeavor: First, alcoholic populations are not homogeneous and patients require different types of help. This suggestion appears applicable when dealing with the problem of alcoholism among psychologists because heterogeneity exists in both job function and membership characteristics (Thoreson & Skorina, 1989). Second, the particular moment at which help is sought by the person with an alcohol problem has its own significance. Those who treat professionals must be sensitive to this issue of timing, and everything possible needs to be done to confirm the potential of this particular moment. Third, goals should be agreed upon rather than imposed. This recommendation is especially important for working with psychologists, because joint decision making is a critical factor in motivation for treatment and recovery (Thoreson & Skorina, 1989). Also, the type of therapist is important. Miller (1985) stated that the therapist factor is a major, yet infrequently considered factor in both motivation for treatment and recovery for a person suffering from severe alcohol problems. He emphasized that a high level of therapist empathy is a

significant factor in maintaining gains in posttreatment and in reducing the incidence of relapse in persons with alcohol problems. Fourth, participants in treatment who relapse should be identified and plans should be made for treatment and prevention of relapses. This recommendation fits well with an emphasis on posttreatment aftercare planning for the professional that focuses on self-monitoring and other relapse-prevention strategies (Thoreson & Skorina, 1989). Finally, the family should be included as an integral part of the recovery process. The spouse or family should be involved in initial assessment, in treatment, and in posttreatment planning. This suggestion is consistent with the research that has identified the critical role of a maximally supportive, consistent environment in treatment outcomes (Thoreson & Skorina, 1989).

Edwards (1982) believed that treatment should occur in an outpatient setting except for detoxification or treatment for underlying or accompanying medical conditions. This treatment recommendation is a radical departure from current practice. However, it is consistent with the outcome studies that show limited effects of alcoholism treatment and with recommendations for more emphasis on posthospital treatment and relapse prevention or sobriety maintenance experiences (Emrick & Hansen, 1983; Thoreson & Skorina, 1989).

Additional factors to be considered in developing an optimal plan of relapse prevention for alcoholic psychologists are: (a) genetic predisposition, indicating that some people can ingest large amounts of alcohol without noticeable ill effects; (b) psychological predisposition, indicating that some persons become more socialized toward drinking; (c) physiological, cell-adaptation factors, indicating that some individuals become more dependent

on alcohol; and (d) absence of a stable social environment, indicating that alcohol is used to increase stability (Tartar, Alterman, & Edwards, 1985; Thoreson & Skorina, 1989; Vaillant, 1983).

Alcoholism Among Psychologists

As mentioned previously, empirical data concerning alcoholism among psychologists is severely limited. However, there are a few researchers who have sought to collect empirical data concerning the issue of alcoholism as it pertains specifically to psychologists (e.g., Skorina, Bissell, & DeSoto, 1990; Thoreson, Budd, & Krauskopf, 1986a, 1986b; Thoreson, Miller, & Krauskopf, 1989). A detailed summary of their applaudable efforts will follow. The practical significance, methods, and results of this research will be reported.

According to Thoreson et al. (1986a), the investigation of alcohol-related job patterns for professionals has both practical and theoretical importance. Practically, it contributes information that may be used by treatment providers in assessment of alcohol problems. Theoretically, it may also contribute toward a model of the interrelationship of the professional's characteristics, work environment, and alcohol-related behaviors that serve to maintain alcohol abuse.

Thoreson et al. (1986a) viewed the data on alcohol-related behaviors of psychologists as prototypic of professionals in general, emphasizing that psychology has the advantage of diversity of job functions and work settings that cover much of the professional world. For example, psychologists may be involved in health care delivery, research, educational, industrial, and organizational management, and private practice.

Thoreson, Budd and Krauskopf (1986a) examined the prevalence and effects of alcohol misuse and mental health problems on work behavior

among professionals using psychologists as prototypic of professionals. Members of the American Psychological Association (APA) completed the Needs Assessment Survey (NAS) for this study. This survey was developed by the researchers concerning colleague alcohol misuse and mental health problems. The Needs Assessment Survey was authorized by the APA to help establish guidelines for the profession of psychology to find effective and humane ways to deal with alcohol misuse among APA members. The initial sample for this study consisted of 1,000 members of APA. Subjects were selected by APA to be representative of the total membership on the basis of age, sex, and APA divisional membership. A total of 507 respondents returned the research instrument to make up the final subject population.

Results regarding awareness of alcohol problems indicated that at least one third of the respondents knew of colleagues who misused alcohol on the basis of fairly overt signs of impairment. Only a select few of the subjects (n=61) confronted colleagues about their alcohol abuse. Those who did the confronting tended to be older men who saw clients with alcohol problems. In contrast, many more respondents confronted colleagues about their mental health problems (n=182) and had better treatment outcomes. For Thoreson et al., one of the most important findings of this study was the large number (33%) of the total sample of psychologists who reported knowing colleagues who had a problem with alcohol misuse. A majority of the 33 percent indicated that they saw their colleagues intoxicated at inappropriate times or saw them with hangover symptoms (shakiness or nausea). Regardless of the perception of strong adverse effects of alcohol misuse on job performance and personal life, almost all of the respondents (42%) who reported being aware of alcohol misuse among their psychologist

colleagues reported that those colleagues had done nothing about their alcohol abuse except to maybe become more cautious about their drinking.

The researchers reported that analysis of these survey results by sex revealed the following significant within-group comparisons ($p < .05$, all cells having at least 10 subjects). First, no differences by sex based on number of clients seen with alcohol problems were observed, although more male psychologists reported knowing colleagues with health problems related to alcohol abuse. Second, women were seen as having fewer problems of alcohol misuse and also a lower incidence of mental health problems. (This finding is consistent with results found in a study of mental health professionals by Elliott and Guy (1993) which revealed that women in mental health professions were generally less distressed than were other professionals.) Third, both men and women reported more alcohol (and mental health) problems for male psychologists. Fourth, the difference in reported incidence of alcohol problems for men and women was significant ($p < .05$).

Pertinent to the effects of denial, Thoreson et al. (1986a) revealed in their results several indicators of the tenacity of alcohol problems among psychologists. Respondents who had confronted a colleague (n=61) reported that when confronted, more than half (56%) of these colleagues minimized the significance of their problems, and slightly less than half became defensive, denying they had a problem (40%). Those who chose not to confront a colleague (n=109) stated they lacked tangible evidence of the alcoholism's negative impact on job performance (57%) or they thought it would not do any good (53%). The reason for not confronting a colleague, as noted by the researchers, was not perceived lack of severity of the problem.

Only 12 percent of the nonconfronters indicated that they believed that their colleagues' alcohol problem was only temporary and that it would clear itself up eventually.

There has been much discussion about the reluctance of colleagues in various professions, including psychology, to confront their peers about alcohol misuse or to intervene in any way, and what impact that may have on the alcoholic's recovery or lack thereof (e.g., Bissell & Haberman, 1984; Thoreson et al,. 1986a). Guy (1987) addresses another important factor, which is the impact that the psychologist who is impaired by alcohol misuse will have on his or her clients. He addresses the fact that clients may recognize the therapist's impairment and for a number of reasons may choose to stay in treatment with the impaired clinician, which most likely will not benefit the client. It is important for the psychologist who suffers from alcoholism to be confronted by colleagues or others about the problem when it is recognized, for the alcoholic's sake and for the sake of the many clients who may be harmed directly or indirectly as a result of being in treatment with an alcohol impaired therapist. Another distressing finding by Guy, Poelstra, and Stark (1989) in a nationwide survey of psychologists practicing psychotherapy was that those respondents reporting recent substance abuse were also the ones most likely to deny the impact of their resultant distress on patient care. This is consistent with the strong denial factor that seems to be inherent among those who abuse alcohol.

Thoreson, Budd, & Krauskopf (1986b) conducted another study which investigated through survey sampling procedures using the Alcohol Job and Sobriety Experiences Inventory (AJSEI), the demographic, alcohol use, drug use characteristics, work behavior, and recovery experiences of 108

psychologists in Psychologists Helping Psychologists (PHP), a.. abstinence-based recovery organization mentioned earlier in this review. Respondents were similar to psychologists in APA and to other health professionals with drug and alcohol problems. The majority of respondents were in good recovery and tended to use a wider variety of relapse-prevention strategies as their length of sobriety increased. Subjects reported several indicators of alcohol-related work impairment, which was observed by colleagues, yet again, seldom mentioned to the alcohol abuser. Some of the results revealed that alcohol-dependence and quality of sobriety were related to relapse, and that the use of a wide range of relapse-prevention strategies and satisfaction with several life areas were related to the length of sobriety.

The AJSEI is a 92-item, self-report inventory with which the following areas are assessed: demographics, alcohol and drug use, work environment, alcohol-job related characteristics, sobriety experiences, and the current status of significant life areas. Good stability among items in each area of the instrument were found, according to the researchers, using a post-hoc principal-components factor analysis with varimax rotation. Additional item-scale total score analysis gave some evidence of the construct validity of the various dimensions.

Three primary areas concerning alcoholic psychologists were analyzed by Thoreson et al. in this study. These areas were respondent characteristics including an analysis by sex, active drinking behavior correlates, and treatment-seeking and sobriety experiences. A multiple regression analysis was performed in order to identify the variables that were most predictive of maintenance of sobriety from a tendency to relapse. On the basis of a priori groupings of items, the variables thought most likely to contribute to

their prediction model were: degree of alcohol-related work behavior, total number of alcohol dependence symptoms, amount of time spent in Alcoholics Anonymous, number and frequency of use of relapse-prevention strategies, and general satisfaction in different life areas.

A total of 16 percent of the respondents indicated that they had a problem with mood-altering prescription drugs along with their active alcoholism. Those who reported current use of prescription drugs had the shortest period of sobriety ($p < .05$). Respondents who reported more symptoms of alcohol dependence were more likely to have used tranquilizers ($p < .02$) and to have a family history of alcoholism in a first-degree relative ($p < .02$). Almost half (46%) of PHP members sampled indicated that they had sought formal treatment for their alcoholism without having been confronted about their work performance, mood changes, or alcohol use. This is consistent with psychologists' reported low rates of confronting colleagues for alcohol misuse(Thoreson et al., 1986a).

Thoreson et al. (1986b) found that the majority of respondents (94%) reported abstinence, and of this 94 percent, 86 percent attended Alcoholics Anonymous. Most of those reporting abstinence (70%) had first contacted AA at least 5 years prior to this study, and 93 percent had contacted AA before joining Psychologists Helping Psychologists. Most of the sample (68%) attended AA meetings at least once a week; many (65%) had a sponsor (though they were infrequently used), and 68% had served as discussion leaders in closed meetings (i.e. those in which attendance is restricted to other alcoholics); and 77 percent had told the story of their progression and recovery in a meeting.

These researchers (Thoreson et al., 1986b) were also interested in the

prediction of relapse. Through their analysis they identified two variables (R=.42) that were significantly related to the number of relapses reported: (a) alcohol- dependence symptoms, and (b) the quality of sobriety. These variables appeared to be interactive, indicating that greater alcohol-dependence symptoms determine a more unstable recovery process, with more frequent relapses. The negative relationship between quality of sobriety and number of relapses suggests that more frequent relapse preempts quality recovery in other life areas. Of the revised variables, degree of alcohol-related work behavior, total AA involvement, sex, and number of relapse-prevention strategies used did not contribute to the prediction model.

After conducting a second multiple regression with the revised group variables, in which reported length of sobriety was the dependent variable, the researchers found the number and frequency of use of relapse-prevention stategies and the quality of sobriety were significant predictor variables (R=.43). Thoreson et al. report that this finding along with previous results suggests that length of sobriety is facilitated by more frequent use of a variety of relapse-prevention strategies, and as the length of sobriety increases, so does the quality of life (or degree of satisfaction with life). Although the exact contribution of AA as a moderator variable in the length of sobriety cannot be directly determined from this study (because amount of time spent in AA was not predictive of either variable), amount of time spent in AA was moderately related to relapse-prevention strategies (r=.47), which were predictive of length of sobriety.

Thoreson et al. (1986b) drew several conclusions from the results of this study. First, the results indicated an excellent level and quality of

recovery from alcoholism for a sample of psychologists who reported major alcohol-dependence symptoms, a pattern of multiple drug use, and demonstrable work impairment during their active drinking. Second, results confirmed that major, observable alcohol-related work impairment resulted from the reported alcohol misuse, which is consistent with findings in the earlier study (Thoreson et al., 1986a). Alcohol-related impairment in job performance appears to be obvious to both the psychologist with the alcohol problem and to his or her colleagues, not hidden as is often suggested. Failing to identify alcohol abuse does not seem to be the problem, but failing to confront it does. Lastly, although the contribution of AA to sobriety cannot be precisely determined, there was a tendency for respondents with longer sobriety to more frequently use a variety of relapse-prevention strategies and to become more involved in the AA program. The implication of AA involvement as a positive factor appears significant, given the overall high AA usage, and the high percentage of the sample (90%) in abstinence-based recovery through AA.

Thoreson, Miller, & Krauskopf (1989) investigated the level and types of distress in a sample of 379 psychologists, using survey methodology. Overall, subjects were healthy and satisfied with work and interpersonal relationships. Some of the respondents (10%) experienced distress in the areas of depression, marital/relationship, physical illness, loneliness, and alcohol use. A subsample of subjects in distress from alcohol use were characterized by use of controlled drinking strategies with notable failure of these strategies to reduce distress. Regarding this area of the study, the researchers concluded that controlled drinking stategies do not function to reduce distress among problem-drinking psychologists.

Of their sample (Thoreson et al., 1989), 9 percent indicated that drinking was a problem, and 6 percent recognized it as a current problem. Those who reported that alcohol use was a current problem, 24% were abstaining from alcohol, whereas 76% reported that they continued to drink in a controlled manner. The researchers used a quantity-frequency criterion (drinking several times per week to daily, at levels of five or more beers, four or more glasses of wine, or half a pint or more of liquor) to identify dysfunctional alcohol use. According to this criterion, 9% or 34 of the total sample were currently drinking dysfunctionally. Characteristics that identified the alcohol-misusing group, in comparison with the total sample, were a higher frequency of divorce (33% vs. 18%); less satisfaction with marriage/relationship (23% vs. 70%); increased gloomy, blue, or depressed feelings (20% vs. 11%); greater incidence of disabling anxiety (7% vs. 1%); smoking cigarettes (27% vs. 11%); and recurrent physical illness (13% vs. 9%).

The researchers compared the 76% (n=19) of the subsample who reported dealing with alcohol problems through controlled drinking strategies with the remainder of the sample (n=360), and the following trends were found: The controlled drinkers reported a greater incidence of dissatisfaction with marriage, feeling less needed and useful, a greater incidence of unpredictable moods, less satisfaction with sexual desire and performance, and a higher incidence of recurrent physical illness (all significant at $p>.05$).

Variables that were correlated at $p<.0001$ with increasing patterns of alcohol consumption in this study (Thoreson et al., 1989) were smoking cigarettes, recurrent physical illness, and non-diet-related changes in eating patterns. The prevalence of problem drinking among their sample of

psychologists fell within the 6%-9% range. The researchers concluded that problem drinkers in this sample were clearly distressed. They differed from the sample as a whole in that they had a higher incidence of life difficulties interpersonally, intrapsychically, and physically.

Much of the information about alcoholic professionals has been obtained from interview studies of 450 physicians, dentists, nurses, social workers, and attorneys (Bissell & Haberman, 1984; Bissell & Jones, 1976). Except for a mail survey by Thoreson et al., (1986b), there had been no similar study of alcoholic psychologists, until Skorina, Bissell, & DeSoto (1990) conducted a similar interview study with 70 currently sober alcoholic doctoral-level psychologists. Each subject was self-described as both "alcoholic" and a "member" of Alcoholics Anonymous, and had to be abstinent from alcohol for at least one calendar year at the time of interview. Thirty-four of the sample were men and thirty-six were women. The subjects median age was 50 years old and they had been sober since a median age of 43. The researchers sought information about the psychologists' alcoholism history, the visiblility or detectability of their alcoholism to others, professional sanctions and interventions, treatment experiences, and eventual routes to sobriety.

Skorina et al. (1990) interviewed abstinent alcoholic psychologists using a structured interview previously used in studies of other alcoholic professionals. Histories and experiences of the psychologists closely resembled those of other professionals. Similar to other professionals, psychologists had exhibited relatively advanced, visible signs of alcoholism, but professional sanctions were rare and almost never combined with effective intervention. Although a majority had received professional

treatment, the treatment was usually inappropriate or ineffective. Most subjects had recovered or attained sobriety outside of formal intervention programs or professional therapy or treatment. Recovery, surprisingly, depended excessively on happenstance events.

Histories for the alcoholic psychologists in Skorina et al.'s (1990) study were very similar to those reported in previous studies of other alcoholic professionals (Bissell & Haberman, 1984). The benchmarks were experienced in exactly the same order and at about the same age for psychologists as for other professionals (e.g., drinking regularly, drunk regularly, drinking interfered with life, other's concern, own concern, and last drink). Subjects took their first drinks (other than childhood sips) at a median age of 17 years, progressed to regular drinking in about a year, and began getting drunk with some regularity after two more years. They felt that alcohol began to interfere in their lives (whether they were aware of it at the time or not) at a median age of 24.

The researchers report that someone else first expressed concern to the alcoholic psychologist about the drinking at a median age of 28.5 years. The alcoholics themselves became concerned about their own drinking somewhat later, at a median age of 30 years. However, it was another 13 years before they attained their current abstinence. Active alcoholism, as measured from the time at which drinking interfered with their life until abstinence was attained, typically spanned a full 19 years. Many members of the sample had made serious suicide attempts (25% of the men and 12% of the women). Rich et al. (1988) noted that alcohol and drug abuse are common in the histories of both men and women who have committed suicide, a point that highlights the seriousness of the predicament faced by

alcoholic psychologists.

A substantial number of subjects (44% of the men and 13% of the women) reported that colleagues (friends or co-workers) informally admonished or confronted them about their drinking. However, these informal admonitions by peers were found to have had little effect. Some subjects (27%) had been warned about drinking by an employer or supervisor. Only 22% had ever had an actual discussion of their drinking with supervisors or employers, and these warnings and discussions in general did not result in effective interventions.

The researchers (Skorina et al., 1990) report that although many people interviewed were, by their own admission impaired while working, not one lost the privilege to practice psychology through revocation of a professional license, nor did any subject report that a license had even been seriously threatened. None of the psychologists had any formal grievances brought against them either by the licensing board of their state or by any state or national ethics committees. Nevertheless, 27% said that they had been unemployed because of drinking. The researchers note that it is remarkable that the degree of impairment and even job loss reported by these subjects coexisted with the almost total absence of interventions that might have directed them into effective treatment.

There are additional surprising data that warrants mentioning here that Skorina et al. (1990) revealed after asking subjects whether any professional treating person had ever questioned the subject specifically about alcoholism. More than half of the subjects (59%) were never asked about it, and those who were questioned were usually only questioned once and often lied in response. Many (38%) admitted to difficulty with alcohol,

saying, for example, "I think I might have a drinking problem," often voluntarily rather than in response to questioning. However, even when the alcoholic psychologist attempted to be completely truthful, the therapist was likely not to make the diagnosis and in some cases, specifically denied it, saying, "You're not alcoholic; you have another underlying problem."

Skorina, Bissell, and DeSoto's study clearly supports earlier findings that alcoholic professionals rarely receive formal intervention from or attain recovery through the actions of colleagues (Bissell & Haberman, 1984; Thoreson et al., 1986b; Thoreson et al., 1983). Skorina et al. (1990) pose an interesting question, "Why do they (psychologists)...do so little to help their impaired and distressed colleagues?" It would be expected for psychologists to be more aware and capable of responding appropriately to alcohol abuse, however, the research results are saying otherwise. Skorina et al. (1990) offer some plausible explanations as to why this may be the case. Even though they are psychologists, they may lack training in how to deal with alcoholism or they may have had a kind of training that impedes action. Specifically, lack of training in confrontation and active intervention techniques may make appropriate action difficult. The researchers also report that at the workshop on Impaired Psychologists at the1989 APA annual convention it was revealed that only two states had active intervention programs for impaired psychologists; Georgia and Tennessee.

To conclude this section concerning alcoholism among psychologists, some of Thoreson and Skorina's (1989) recommendations for treatment of alcoholic psychologists will be summarized. They describe a variety of treatment strategies tailored to characteristics of psychologists, their work environments, and societal attitudes, which may be helpful for working with

psychologists suffering from alcohol abuse.

First, psychologists with alcohol problems are resistant to recognizing and accepting the problems, so it may be best to deal with the presenting problem, while at the same time listening for alcoholism. In helping the psychologist gain insight into his or her alcoholism, it is more effective to provide services that include an educative/developmental component rather than to focus exclusively on alcohol problems. Second, disengage from the learned-behavior-versus-disease controversy. The important aspect is to help the alcoholic psychologist gain as much clarity about their problem as is possible and to develop appropriate strategies for coping with the problem. Miller (1985) reported that a direct attack that focuses on the negative aspects of denial and rationalization is similar to forcing the alcoholic client to fit into a particular view of therapy, which is destructive, and leads to higher relapse rates. Third, use finesse in confrontations. There is likely to be a connection between decline in job performance and alcoholism, and this can be determined only by reference to an individual's performance over time. Using finesse will enable the psychologist with an alcohol problem to look at her or his own picture of decline. An alcoholic psychologist may experience a decline in cognitive functioning and memory which may lead to feelings of panic and shame. The therapist may refer to this gently by asking, "Is your work as good today as it was a year ago?" This may help the psychologist to slowly open up and begin to face the despair and shame felt over the problem of alcoholism.

Fourth, empower psychologists to be consultants on their own alcohol problem. Encourage them to use all their resources in attaining a full understanding of their problem. Fifth, stress the complexity of alcohol

problems and the "life-of-its-own" (one lives only to drink and drinks to live) aspects. While actively drinking, the psychologist has no means of controlling their life. Maintaining a facade of normalcy while enmeshed in alcoholism requires enormous effort as well as a set of strategies to enable the psychologist's alcoholic drinking to continue. Sixth, emphasize behavior, not labels. Focus directly on the behavior that results from using alcohol. Seventh, provide models of sobriety. Provide the psychologist with an opportunity to gain exposure to psychologist peers who have similar alcohol problems and occupational characteristics and are likely to share their personal experiences with alcohol, their solutions, and their experiences in living life sober. Eighth, acknowledge the presence of guilt and shame, and be prepared to discuss the paradox involved in gaining power over the addiction through admission of powerlessness over alcohol.

Ninth, develop a relapse-prevention protocol. Encourage the psychologist to develop a set of self-management strategies that can be used to prevent relapse, increase their sense of empowerment and self-control, and take advantage of their problem-solving orientation. Brown (1985) found that posttreatment stressors, limited social support, and drinking expectancies predicted relapse. She recommended that treatment include relapse-prevention strategies to deal with the drinking expectancies and limitations of environmental support. A combination of professional treatment that emphasizes relapse-prevention strategies and mutual self-help support from psychologist peers via AA is recommended. For the private practitioner, this could also include peer-consultation groups as a support system to prevent stress (Greenburg, Lewis, & Johnson, 1985).

Tenth, insist on an alcohol-free and drug- free status. Thoreson and

Skorina's position is that the psychologist be willing to be drug and alcohol free as a prerequisite to psychotherapy. They believe that the road to recovery for those with severe alcohol problems begins when the individual becomes free of the toxic effects of alcohol. Further, a valid separation of alcohol-induced behavior from patterns while not under the influence of alcohol, is not possible until the person is detoxified. Psychotherapy for those who are actively drinking, as a means of eliminating problems other than alcohol, is likely to fail, to be personally unsatisfying to the psychotherapist, and to be potentially damaging to the psychologist-client.

Finally, be cautious regarding other drug use. The use of drugs other than alcohol should be considered a positive factor only under the following circumstances: (a) if needed for medical problems such as diabetes, epilepsy, arthritis, or heart disease; (b) in the instance of demonstrable psychopathology such as diagnosed schizophrenia or manic depressive conditions; and (c) when needed for the short term as a means of abating a crisis, for example, the use of antidepressants such as tricyclics. Minor tranquilizers are contraindicated except when used in detoxification. Many alcoholic professionals have been addicted to minor tranquilizers as well.

Implications for Further Research

There is a need for more empirical research concerning the issues of alcoholism among psychologists. Very few studies have been done in this specific area, and results of an extensive literature search revealed that apparently there have been no studies in the area of alcoholism among psychologists since Skorina, Bissell, and DeSoto (1990) published their research results. The research that has been done in this area has been conducted by a handful of the same researchers. If more researchers would

become involved in this specific area of study, it may enhance what has already been discovered and may benefit those in the profession of psychology who suffer from alcoholism as well as those who desire to effectively aid in a colleague's recovery from alcoholism.

Much of the information available has been obtained by means of self-report inventories or surveys, results of which may be subject to bias. Due to the limitations of survey data, use of additional methods would seem advantageous, such as structured interviews similar to those conducted by Skorina et al. (1990), which were similar to previous studies reported by Bissell and Haberman (1984) on other professionals with alcoholism, allowing for comparison to other professional groups. Open-ended interviews could be used to collect more specific or relevant data that may not be covered in the structured, time-limited interviews. Interview techniques may be hampered by interviewer bias or by non- standardization of the interviews.

Future research should be directed at a larger and more varied sample which would help provide more generalizable results. It would also be informative to conduct studies that focused specifically on female psychologists, as much of the studies on alcoholic psychologists have consisted of over fifty percent males; and much of the literature about alcoholism in general has come from studies using mostly male populations. There appears to be a dearth of specific information regarding the female alcoholic.

The studies that have been done thus far often lack internal validity, as there is a dearth of experimental control and random selection and assignment of subjects. Due to the nature of alcoholism, however, it is

difficult to implement experimental controls in order to make the results less tenuous. There is a need for more longitudinal studies which would be able to account for the effects of alcohol on psychologists and treatment strategies over time. Outcome comparisons of those receiving treatment early versus later in their drinking careers would be valuable also.

Research is needed that will further delineate the treatment history of a more representative sample of psychologists, their patterns of alcohol and drug use, their family support systems, and their work history both before and after recovery. It is recommended that results from existing studies be compared with findings from psychologists with other alcohol and drug misuse patterns, especially those who present fewer alcohol dependence symptoms, those who have achieved a successful nonabstinence goal (including moderate drinking), those who have achieved abstinence without Alcoholics Anonymous, and those who show a more typically higher relapse rate. Moderate statistical reliability of reported alcohol consumption patterns constituted a limitation to some of the studies; therefore, improved measures of alcohol consumption rates should also be included in further studies.

Many questions remain that have yet to be answered concerning the alcoholic psychologist. The answers to these questions may have implications for both the treatment of alcoholism and the profession of psychology. Questions regarding work-related behaviors affected by alcohol use, effective coping strategies, patterns of treatment, and current work behaviors of professionals in successful recovery are of great importance. Investigating family of origin patterns, incidence of alcoholism among family members, and possible correlations between antecedent events that led to

choosing a career in psychology and antecedent events that may have exacerbated a tendency toward the development of alcoholism in the psychologist. It is hoped that the research will continue concerning alcoholism among psychologists, and that it will provide better and more effective intervention techniques and earlier identification of drinking problems.

Summary and Conclusions

Alcoholism, a major health problem that is currently being addressed by other professions, has unique features, manifestations, and ramifications for psychologists. Psychology as a profession has been slower than others in developing strategies and programs to help its members who are distressed by problems such as alcoholism. By training and inclination, psychologists are predisposed to favor a learning model and frequently discount the deleterious health effects and the disease concept of alcoholism. Although there is a significant amount of job-related impairment among alcoholic psychologists as well as major impairment of the family during active alcoholism, few sanctions are applied to professionals, including psychologists.

Alcohol misuse tends to be viewed by psycologists as a permanent disorder with severe and adverse consequences to health, reputation, and work. Psychologists clearly identify the negative work, health, and reputational consequences of alcohol misuse even though they are reluctant to confront their colleagues concerning these issues. A substantial number of psychologists are perceived as having alcohol problems; a small portion of psychologists actually confront such colleagues; and even fewer psychologists

with problems of alcohol abuse and alcoholism seek treatment for their alcohol misuse.

Considering the large number of psychologists identified as having alcohol problems and the ineffectiveness of individual peer confrontation and referral, the need for a responsible plan to help psychologists who suffer from alcoholism that would include information and referral as well as education and prevention has been suggested. Current efforts to effectively and humanely deal with alcoholism within the professions, modeled after the self-help principles of Alcoholics Anonymous in combination with professional treatment, have been used as effective relapse-prevention strategies. The self-help advocacy programs, such as Psychologists Helping Psychologists and Alcoholics Anonymous, are seen as clearly beneficial and of major importance to long-term recovery for alcoholic psychologists.

None of the studies addressed the alcoholic psychologist who is not identified, or who does not accept a referral to treatment. What is the fate of these people, and what is the impact of their continued practice on the public? The challenges to provide effective intervention strategies for the alcoholic psychologist are many, some of which are: to develop effective ways to identify alcoholism among psychologists, to develop effective ways of helping alcoholic psychologists receive appropriate assistance, and to develop ways of handling the difficult problems of relapse and failure.

In conclusion, the incidence of alcoholism among psychologists does not reflect poorly on the profession, as no profession is immune. However, the consequences of failing to detect and to treat the problem of alcohol misuse in psychologists will reflect poorly on the profession of psychology.

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